Pediatric/Adolescent Screening and Immunization Documentation Form

2010-2011 Seasonal Influenza Vaccination Program

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Name of person to receive vaccination (Please Print):	**Sponsor's SSN:**

Circle answers to questions 1-15:

1	Has your child ever received a seasonal flu vaccine?	No	Yes
2	Did your child (ages 6mo-8 yrs only) receive at least one dose of the 2009 A H1N1 vaccine?	No	Yes
3	Does your child currently have a respiratory illness or a fever?	No	Yes
4	Has your child ever had a serious reaction to a flu vaccine in the past?	No	Yes
5	Does your child have a history of Guillain-Barre Syndrome (GBS)?	No	Yes
6	Does your child have an allergy to any of the following: eggs, egg protein, MSG, gentamicin, neomycin, polymyxin, gelatin, arginine, thimerosal, formaldehyde, latex or other vaccine components?	No	Yes
7	Is your child younger than 2 years of age? **(If marked Yes skip questions 8-15)**	No	Yes
8	Does your child have a history of asthma, reactive airway disease or wheezing?	No	Yes
9	Does your child have heart disease, lung disease, kidney disease, metabolic disease (e.g., diabetes), a blood disorder or any other chronic health conditions?	No	Yes
10	Is your child taking aspirin or aspirin-containing therapy?	No	Yes
11	Does your child have a weakened immune system because of HIV or another disease that affects the immune system, take long-term high-dose steroid treatments, or cancer treatment with radiation or drugs?	No	Yes
12	Is your child taking any prescription medicines to prevent or treat influenza? Have they taken any antivirals in the last 48 hours?	No	Yes
13	Does your child live with or expect to have close contact with severely immunocompromised individuals who must be in a protective environment (such as transplant recipients?)	No	Yes
14	Is the adolescent to be vaccinated pregnant?	No	Yes
15	Has your child received any vaccines within the last 30 days or are they going to receive any additional vaccines within the next 4 weeks?	No	Yes
	If you are not sure that the person is registered or received services (pharmacy, lab, clinic, etc.) at Kenner Army Health Clinic, please complete the back of this sheet.		

"I have read or have had explained to me the information in the 2010-2011 Influenza Vaccine Information Statement (VIS). I have also had a chance to ask questions and they were answered to my satisfaction. I understand the benefits and risks of the influenza vaccine."

Signature: _____ Date: _____

Below to be completed by healthcare provider

☐ **Give injectable flu vaccine today**

☐ **Give intranasal flu vaccine today**

☐ **Do not administer flu vaccine today**

Vaccine Information Statement provided (check box)

☐Inactivated Influenza Vaccine (TIV)

☐Live, Attenuated Influenza Vaccine (LAIV)

Interviewer's Signature	**Date**

Vaccine Administered

Live Intranasal Influenza (FluMist, MedImmune)

Lot # _____

Dose: 0.2 ml **Route: Intranasal**

Comment:

☐**Inactivated Influenza** - 6 mo and older (Fluzone, Sanofi-Pasteur)

☐**Inactivated Influenza –** 9 yrs and older (Afluria, CSL)

Lot # _____

Dose (6-35mo): 0.25mL Route: IM (6-12mo)Thigh L / R

IM (>12mo) Deltoid L / R

Dose (≥36mo): 0.5mL Route: IM Deltoid L / R

Administered by:	**Date**

If you're not SURE that you've been seen or registered at Kenner Army Health Clinic

– please complete this portion

LAST NAME, FIRST NAME, M.I. _____

SPONSOR'S SSN: 20/_____ **DOB** _____

SEX (CIRCLE ONE**) MALE FEMALE RANK**_____

UNIT _____ **UNIT PHONE** _____

HOME ADDRESS: _____

LOCATION OF MEDICAL RECORDS _____

LIST ALL ALLERGIES AND SIDE EFFECTS SEEN: NO ALLERGIES _____

1. _____
2. _____
3. _____

DO YOU HAVE ANY OTHER HEALTH INSURANCE? ____YES ____NO

IF YES, PLEASE PROVIDE THE NAME OF THE HEALTH INSURANCE COMPANY _____